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LOYOLA UNIVERSITY CHICAGO

PREDICTORS FOR THE UTILIZATION OF MENTAL HEALTH  
SERVICES AMONG ACCULTURATING ASIAN INDIAN PROFESSIONALS

A THESIS SUBMITTED TO  
THE FACULTY OF THE GRADUATE SCHOOL  
IN CANDIDACY FOR THE DEGREE OF  
MASTER OF ARTS

DEPARTMENT OF PSYCHOLOGY

BY  
VINITA MENON

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## CHAPTER I

### INTRODUCTION

The increasing attention given to the field of cross-cultural psychology can be acknowledged as essential to one's understanding of individual and group psychology. While it is understood that each ethnic minority group has a unique cultural heritage that distinguishes it from the dominant society, this uniqueness also separates one minority group from other minority groups. Earlier researchers (Ruiz & Padilla, 1977 and Sue & Sue, 1990) have warned that, in addition to intragroup differences, attitudes of individuals toward their ethnic identity can vary greatly as their acculturation level changes. In studying the utilization and effectiveness of mental health services by minority populations, acculturation has been viewed as an important variable to consider (Cheung & Snowden, 1990).

#### Asian Indians in the U.S.

A general description of the Asian Indian population in the United States (U.S.) is warranted at this point. Asian Indians constitute a relatively small population in the U.S. and have been a presence in this nation for approximately 25 years. Indians in the U.S. demand one's attention at this juncture for several reasons. First, as an immigrant community

they are distinctly different from both the earlier wave of European immigrants to the U.S. as well as from more recent immigrant groups. A predominant portion of Indians who immigrated in the wake of the 1965 Immigration Act were highly educated and technically skilled professionals who, in a relatively short period of time, found themselves in the middle and upper socio-economic levels of American society. In fact, they were welcomed in the U.S. because of their professional skills or their potential technical contributions. In 1981, the U.S. Census Bureau reported that 3.5 million Asians in the U.S. comprised 1.5% of the U.S. population and that Asian Indians, numbering 363,000, were the fourth largest Asian group (U.S. Bureau of Census, 1981). The 1990 Census data indicates that Asian Indians, still the fourth largest Asian group, numbered 815,447.

Indians number 64,200 in the state of Illinois (approximately 8% of the national figure). Of that, 16,386 live in Chicago and it's suburbs, according to 1990 Census data. Although Asian Indians are a growing minority group within the fabric of American society, their social, civic, and political involvement in mainstream American society is not commensurate with their professional success. Most intended to remain in the U.S. permanently; yet, in many ways they have not broken their ties with India. This lack of involvement is evidenced by the tendency to establish neighborhoods with a distinct Indian identity and a reluctance to progress toward marital



integration and religious conversion, common changes that have evolved in other immigrant groups (Sodowsky & Carey, 1988).

## CHAPTER II

### REVIEW OF THE LITERATURE

#### Cultural Characteristics of Asian Indians

Since there exists a scant descriptive literature of this population, the following discussion consists primarily of beliefs held by the author. Between 1980 and 1993, only 20 to 25 citations were located that were related specifically to Asian Indians. Indians are distinct from other minority groups in that, physically, they have what some would call a "non-white, non-black appearance." Individuals outside this ethnic group seem to have difficulty deciding whether Asian Indians are more like African Americans, Hispanic Americans, or other Asian Americans (Sowell, 1981). Unlike other Asian Americans, there is a broad range of skin and hair color in this population. Also, Asian Indians do not have straight hair and "slanted" eyes that is often characterized with Asians. Although India forms a major part of the sub-continent of Asia, Indians are not popularly considered Asians-that term being reserved primarily for East Asians (Sowell, 1981).

A second significant aspect is that this community represents an increasingly important segment of the American mosaic on which little academic work has been conducted. Considering that the 1990 Census indicates that the group is just under one million members, the size of the psychological literature does not reflect this growing community. This

condition may be attributed to the Asian Indians' tendency to blend in with the dominant culture and conceal adjustment problems that may arise (Helweg & Helweg, 1990). A strong sense of shame would have to be overcome before problems were shared. There also appears to be conflict between Asian Indians and other Asian groups in the form of competitiveness. This competition extends from the classroom to the acquisition of material wealth and professional stature (Helweg & Helweg, 1990). The combination of reticence and superiority makes Asian Indians a challenging population for academic study.

#### Cross-Cultural Assumptions

An assessment of this population may reveal significant insights into the "success myth" and its masking effect of psychological problems within the Asian Indian community (Kim & Hurk, 1983) and the Indians' inclination to keep problems to themselves. In keeping with general Asian culture, there is heavy emphasis on the preservation of traditions, self control, withdrawal and general inward orientation among Indians, whereas Americans stress outwardness, freedom, change, progress, action, and enjoyment (Kim & Hurk, 1983). In the area of psychological research, insights into the Asian Indian culture would expand the available knowledge base for educators, clinicians and counselors. The move towards multiculturalism and culturally congruent counseling would be bolstered by this expanded knowledge base. Culturally

congruent counseling would involve adapting the counseling style and assumptions to suit philosophical, religious, and familial traditions of the client population being served. For Asian Indians, making counseling more culturally congruent would require an emphasis on understanding karma. Karma is an Eastern theological idea meaning destiny; the doctrine that one's present actions exert influence on future experiences (Kakar, 1991). Those clients who believe in karma would be likely to present as more passive as they see themselves as a smaller component that must be in harmony with the larger framework of society (Kurian, 1986). The relational model of self is likely to represent the way in which the Asian individual sees the relationship between self and other. In this model, the person is to derive one's nature interpersonally; therefore, individual problems can be construed as disorders of relationships within human, natural, and cosmic orders. The need for attachment, connection and integration with others represents the primary motivation of the individual, rather than an expression of biological individuality (Kakar, 1991).

Kakar (1991) contrasts Eastern and Western therapeutic assumptions. Freud and others believed that psychoanalysis expressed laws that were scientific and as universally true (Kakar, 1991). But, the "psyche" has had different histories in the East and West. Kakar explains that the Western assumptions that are inherent to counselor identity stem from

an individualistic model whereas the Eastern assumptions stem from a relational model and are inherent to Asian Indian client identity; therefore, the goals of Western psychotherapy, which are related to the individual, would be in contrast to the Asian relational framework. In the West, a person is limited and defined by the physical body while the Eastern viewpoint is that a person is a microcosm of the whole natural and supernatural world. The source of strength, in the Asian view, is found in integration with one's group.

Kakar's work as an analyst in India has led him to conclude that those patients who are not highly "Westernized" or acculturated will usually not recognize their emotional problems as having originated in the psyche. Rather, these clients would attribute psychological problems to a source outside the individual, either to malevolent spirits or residual effects from a previous life. When these patients are asked to introspect, the Asian culture inherent in their personalities interferes with their ability to effectively introspect.

The convergence of Asian culture and Western psychotherapy is difficult if therapist and patient do not share fundamental cultural assumptions about human nature. Psychotherapy can only begin when there is conflict, either internal or between the individual and the environment such that the contrast causes emotional or physical discomfort.

While this level of cultural incongruity in the

counseling process may not be fully understood by the average client, it is at least one barrier of service utilization. The current population of Asian Indian professionals in the U.S. is at risk for adjustment problems because they lack the familial supports available to them in India. The professional population is particularly vulnerable because of the significant life stressors associated with family, career, and success coupled with possible feelings of cultural isolation and maladjustment; therefore, an external source of support would seem to be helpful. At the same time, this population is likely to be similar to the clients described in Kakar's article in their understanding of self in relation to their environment; consequently, the support resources prove to be unattractive because they are culturally incongruent and perceived to be more appropriate for individuals of European descent.

#### Minority Utilization of Mental Health Services

Cheung and Snowden (1990) reviewed the national trends in minority utilization of mental health services. These researchers felt that community based surveys were an excellent source of information about minority utilization. For the Asian American/Pacific Islander group, only a "slim body of research lacking in community based surveys" (p.281) had been found. Even within this small source of information, there have been consistent findings of underutilization

relative to their proportion of the general population, for all types of mental health services.

Data from community based surveys have found consistent patterns of underutilization for other ethnic minority groups as well. For example, Hough, Landsverk, Karno, Burnam, Timbers, Escobar, and Regier (1987) found that Mexican Americans were considerably less likely than Caucasians to have made a visit to a professional for mental health reasons. In the use of mental health services, Wells, Hough, Golding, Burnam, and Karno (1987) found Caucasians to show evidence of greatest utilization, highly acculturated Mexican Americans an intermediate level of utilization, and low acculturated Mexican Americans lowest utilization. Asian Americans were less likely than Caucasians to have seen a psychiatrist or other professional for mental health reasons (Yu & Cypress, 1982). Other researchers have found that Asian, Hispanic, and African Americans prefer to keep problems within the family (Lin, Tardiff, Doretz, & Goresky, 1987).

Cheung and Snowden (1990) found that hospital admission rates for minorities with mental health diagnoses increased by 37% between 1970 and 1980. This increase is explained by the authors to be attributable to differential admission rates for African and Native Americans. Possible explanations for this differential use of inpatient care by minorities include: individual and family poverty; declining mental health resources in minority communities; misdiagnosis of symptoms

due to cultural and language barriers and racism (Cheung & Snowden, 1990). These concerns about underutilization and its underlying causes are also relevant to the Asian Indian population.

Researchers agree that Asian, African, and Hispanic Americans have a distinct cultural heritage that differentiates one group from the other (Atkinson, Morten, & Sue, 1989). Yet cross-cultural research has indicated that such cultural distinctions can lead to a stereotypical view of minority group attitudes and behaviors. The belief that all Asians are the same is erroneous and can lead to numerous therapeutic problems (Atkinson & Gim, 1989). Patterns of mental health service utilization may be a function of the cultural or racial identity of the minority person in addition to the variables of race or ethnicity. Assessment of these within-group differences appears indicated among Asian Indians living in the U.S. Understanding their cultural context is crucial before examination of attitudes toward counseling and psychotherapists can be undertaken.

### Acculturation and Ethnic Identity

Acculturation has been described and defined by numerous researchers. Berry's (1983) description of acculturation requires the interaction of two autonomous culture groups, with one group dominating a minority group. The model proposed by Berry has four options of cultural adaptation that reduce



acculturative stress over issues of change and conflict. These adaptation options arise from a variety of possible relationships between the two groups. The four types of acculturation include assimilation, integration, rejection, and deculturation. This model provides flexibility during the evolution of a modified ethnic identity. Assimilation has been defined as the process of becoming more similar to the dominant group (Berry, 1965). Assimilation often involves the loss of some native cultural characteristics and the adoption of other characteristics from the dominant culture. Integration requires the retainment of cultural identity as one moves toward merging with the dominant culture. Using integration, the individual selectively chooses the aspects of dominant culture to be incorporated into his/her ethnic identity. Rejection involves the separation of the ethnic individual from the dominant culture. The separation can be self-imposed withdrawal or segregation by society. Deculturation is the lack of contact by the individual to either culture group. This option is likely to be caused by physical or geographical separation and can heighten feelings of identity anxiety. The basic tenets of this theory can be generalized and applied to other minority groups, such as Asian Americans, specifically Indians, due to a shared experience of oppression. Berry (1965) has also observed that minority groups share the same patterns of adjustment to cultural oppression.

Researchers such as Cross (1970) and Sue and Sue (1990) have studied the process of acculturation and development of ethnic identity in African-Americans and Asian-Americans respectively. Evidence of similar models of minority identity development, regardless of whether the minority is Hispanic, Asian, or African-American suggest experiential validity. Comparisons can be most easily made between African Americans and other racial or ethnic groups. During the past two decades, the socio-political activity of Hispanic and Asian Americans has resulted in an identity transformation for persons within these groups similar to that experienced by African Americans (Sue & Sue, 1990). The common experience of oppression clearly serves as the unifying force in the emerging Third World consciousness.

According to Cross' model, African-Americans progress through four distinct psychological stages as they evolve from a degraded to a secure self-perception. The four stages, ranging from least self-secure to most self-secure are preencounter, encounter, immersion-emersion, and internalization. In the preencounter stage, a person's world view is dominated by a Euro-American frame of reference as he or she behaves in a way that devalues their ethnic identity. Individuals in the preencounter stage seem to view the world as an anti-ethnic minority (Atkinson, Morten, & Sue, 1989). The Asian Indian in this stage may feel that their own physical features are less desirable and their cultural values

are a handicap to successful adaptation into mainstream society. Their attitudes towards members of their own racial/ethnic group are highly negative and they share the dominant culture's belief that Asians are less desirable; however, attitudes toward members of the dominant group are highly appreciative and viewed as ideal models. The encounter stage occurs when an event or series of events occurs which challenges the old frame of reference and allows the person to be receptive to a new interpretation of their identity. The individual begins to validate him/herself as a member of a minority group. The individual may encounter something that conflicts with the attitudes established during the preencounter stage. For example, an Asian Indian who is ashamed of his heritage and feels that the only way to succeed is by minimizing his ethnicity may come across a well respected Asian Indian professional who seems proud of his/her ethnicity. Atkinson et al. suggest that the individual experiences alternating feelings of shame and pride in self and the cultural values of the minority begin to have appeal. While the individual does begin to question the idealization of the majority culture, most of one's introspection is reserved for resolving conflicts pertaining to the individual and his/her minority group. Sodowsky and Carey (1988) offer an explanation to this interpretation of Cross' model when the relationship between generational status and acculturation level are being considered. It is hypothesized that first

generation immigrants who describe themselves as highly acculturated do so because they are at the preencounter stage. That is, they may be enthusiastic about coming to a new country or strongly resolved to face upcoming challenges so that they are currently adaptive and satisfied. Once the initial survival struggles are resolved, the immigrants may become aware of cultural oppression, thus entering the encounter stage (Sodowsky & Carey, 1988). In the immersion-emersion stage the person begins to develop a sense of ethnic pride but this change of attitude is not internalized. During this stage, an individual may seek out more information about his/her own minority culture, experiencing a "home-coming" to ethnic values. For the Asian Indian, this may be represented by a visit to India and an appreciation and adoption of Indian traditions. In the final stage, internalization, the person achieves a feeling of inner security with his or her ethnic identity. The individual is able to reduce the dissonance experienced in previous stages and emerge with a sense of self and sense of ethnicity intact and evolved. This stage is also characterized by a softening of the previously established negative stance toward the minority group. For example, Asian Indians in this stage are likely to form or join socio-political groups or professional organizations to promote their ethnic minority members as an integral part of the fabric of the dominant society.

With Cross' model in mind, it is necessary to examine how

one's understanding of the process of acculturation can be extended. Cross' model pertains specifically to the African American experience but it has also been established that other minority groups do experience similar patterns of adjustment to cultural oppression. The following model is an integration of Cross' model with clinical observations of other minority group experiences. Sue and Sue (1990) have proposed the Racial/Cultural Identity Development Model (R/CID) as a conceptual framework to assist counselors in understanding their culturally different client's attitudes and behaviors. There are five stages of development that oppressed people experience as they progress toward understanding themselves in the context of the relationship between their own culture and the dominant one. In the first stage, conformity, the person has a deprecating attitude towards oneself and other members of the same minority group while holding a positive attitude toward the dominant group. In the second stage of dissonance, the person experiences conflicting attitudes toward self, others of the same minority, and the dominant group. The third stage, resistance and immersion, is characterized by a positive attitude toward self and other members of the same minority group and a deprecating attitude toward the dominant group. The fourth stage of introspection finds the person concerned with the basis or rationale of the attitudes presently held. In the final stage, integrative awareness, the person is selectively

appreciative of self, other members of the same minority group and the dominant group.

### Acculturation and Adjustment

Cuellar, Harris, and Jasso (1980) have studied Mexican American acculturation and have developed the Acculturation Rating Scale for Mexican Americans. This scale was developed for use with Mexican Americans of varying socioeconomic, educational, and linguistic levels. This scale was also designed to be used with both clinical and normal populations. Cuellar, Harris and Jasso, (1980) stated, "Acculturation is a multifaceted phenomenon composed of numerous dimensions, factors, constructs or subcomponents-not all of which have been clearly identified or specified. Values, ideologies, beliefs, and attitudes appear to be important components of acculturation as are cognitive and behavioral characteristics such as language, cultural customs, and practices" (p.209).

Again, within group research seems to indicate a relationship between the level of identity development and the manner in which one can or cannot adjust to cultural changes. Once information is gathered on the acculturation of a particular ethnic minority, models such as those set forth by Cross (1970) or Sue and Sue (1990) can be applied to understand the stage in which the minority's ethnic development lies; subsequently, the level of acculturation or ethnic identity can be studied in relation to behaviors or

activities of the group within the dominant societal structure. One structure of interest to the present paper is the utilization of mental health services by minority populations, specifically the Asian Indian population in the U.S.

### Barriers to Service Utilization

There are problematic trends that can be identified as barriers to service utilization. One trend is the increase in hospitalization as a contributor to the amount of minority utilization. There is evidence that minority individuals are given more severe mental health diagnoses, receive less preventive treatments, and are often seen by less experienced therapists (Cheung & Snowden, 1990). There is also evidence that disruption in service, (i.e., premature termination of treatment, poor attendance), is another problem that troubles minority group members once they have entered the mental health system. Cheung and Snowden also suggested that barriers to service utilization often include factors such as financing, cultural incongruity, organizational deterrents, and bias in diagnostic procedures that prevent racial and ethnic minorities from accessing available mental health services.

The relationship between minority status, financing and utilization of mental health services is unclear. Underutilization of mental health services is as much a

problem in affluent minority groups as it is in economically marginal ones (Cheung & Snowden, 1990). The relationship between cost and use may vary depending on the amount of systematic discrimination experienced and the cultural definition of mental health. Considerable work remains before a distinct understanding of the complex nature of the variables can be articulated.

Sue and Sue (1987) found that the level of stigma or shame associated with mental illness and emotional difficulties, another barrier to utilization, is far more intense in the Asian American population when compared to a non-minority population. For Asian families, an admission of weakness (i.e., mental illness) by one family member is considered a disgrace to the family unit.

A related problem is the lack of culturally adapted programs. Wu and Windle (1980) found that Asian Americans made greater use of outpatient care and avoided expensive hospitalization in spite of this program having a high presence of minority staff and procedures for pairing counselors and clients of the same minority group. Morten and Atkinson (1983) also found that if counselors and clients of the same minority group were paired, it often lead to greater utilization of available services.

Diagnostic procedures are another pitfall for minority populations because expression and interpretation of symptoms vary as a function of ethnic identity. For example, depressive



symptoms in a Chinese patient may be significantly different from those of a Caucasian patient. The Chinese patient would be more likely to present with somatic complaints while the Caucasian patient is likely to present with intrapersonal conflicts (Cheung & Snowden, 1990). Sue and Sue (1974) found that culture can influence the expression, and consequently diagnosis of symptoms. Sue and Sue (1987) argue that inappropriate and invalid conclusions can be reached if cultural factors are not understood.

Butcher and Braswell (1983) suggest that there is a tendency to deliver more serious or pathological diagnoses to minorities and that diagnoses of this nature were more often given by a non-minority professionals. This finding suggests that symptom presentation is influenced by the patient's cultural identity and the professional's sensitivity to differences in presentation.

### Expectations About Counseling

Research on Asian American and specifically Asian Indian client expectations about counseling has been less extensive than research on African or Hispanic American client expectations. Tan (1967) found support for the prediction that Asian American clients would prefer active and directive counselor approaches as compared to passive and nondirective approaches when the Asian clients differed significantly from the American clients. Tan defined active and directive

counselor approaches to be more confrontational, open, authoritative, and problem-solving. In this manner, the Asian American clients would be able to take on a more passive and dependent role in therapy. These expectations are incongruent with Caucasian counselors' expectations such as working as a team toward problem solving and eliciting feedback in order to modify behavior.

Research on minority clients' expectations about counseling has found that many minority clients expect counselors to be more concrete, directive, empathic, nurturant, and expert when compared to non-minority client expectations. As a consequence to these expectations about counselors, minority clients expect to play a more passive role in the counseling process (Yuen & Tinsley, 1981).

The processes of individual, marital, and family counseling are common types of mental health services that can be studied. An instrument developed by Howard Tinsley (1976) measures client expectations about counseling. Yuen and Tinsley (1981), using the Expectations about Counseling (EAC) questionnaire, found similar results when comparing Chinese and American students. Yuen and Tinsley used the EAC to probe the relationship between nationality and expectations about counseling among college students. The study revealed contrasts between expectations of counselor and client when the two differed in ethnic identity.

American subjects were found to expect the counselor to

be less directive and the clients themselves were expected to take more responsibility for the progress of treatment. The Chinese subjects expected the counselor to be more directive and nurturing while the clients assumed a more passive role. Yuen and Tinsley (1981) contend that the results imply that counselors need to be more aware of the culture-based assumptions they hold toward the counseling process.

### Rationale

The underutilization of a potentially beneficial counseling service can be reduced if the mental health industry modifies its approach based on the attitudes of the population it hopes to serve. After studying the literature on the Asian Indian population in the U.S., acculturation and ethnic identity, barriers to utilization of mental health services (identified as the counseling process), one can conclude that an analysis of the factors of acculturation and client expectations about counseling of the Asian Indians is sparse and requires further exploration.

### Hypotheses

The present study attempted to examine the variables most salient to mental health utilization. The following hypotheses were examined:

Hypothesis I: As the measured level of Western acculturation increased, Western acculturated Asian Indian professionals would hold more positive attitudes toward seeking help from mental health professionals than their peers who were less Western acculturated.

Hypothesis II: The measured level of Western acculturation of Asian Indian professionals would be positively correlated with their age of immigration.

Hypothesis III: As generational status since immigration increased, the measured level of Western acculturation of Asian Indian professionals would increase.

Hypothesis IV: Asian Indian professionals who have had previous experience/contact with the Western mental health care system would possess a more positive attitude towards utilizing mental health professionals than Asian Indian professionals who have not had experience/contact with the Western mental health care system.

Hypothesis V: Asian Indian professionals who were more Western acculturated would be less likely to have a preference for mental health care providers who are of the same race than Asian Indian professionals who were less Western acculturated.

## CHAPTER III

### METHOD

#### Participants

Participants in the study were 186 Asian Indian professionals in the Chicago Metropolitan area. Chicago has a large Indian community of 16,386 (U.S. Bureau of Census, 1990). A total of 300 subjects were non-systematically selected from entries in the membership list of the India Medical Association-Chicago Chapter, and the Pink Pages, a directory of Indian owned businesses and practicing professionals. Of the 300 questionnaire packets mailed in October, 1993, 187 usable questionnaires were returned, resulting in a return rate of 62%. Demographic characteristics of the sample are presented in Table 1.

#### Procedure

Participants were mailed a packet containing a battery of questionnaires and a cover letter. The introductory letter informed them that they were being asked to participate in a study that assesses general attitudes about counseling, as well as copies of the Expectations About Counseling Questionnaire, the American International Relations Survey, the Demographic Questionnaire, and the Profile of Mood States. A copy of the introductory letter is presented in Appendix A. Participants were informed that all information gathered would

Table 1

## List of Demographic Variables, Frequencies and Percents

Variable	N	%
Total Subjects	184	100
Age		
21 - 25	18	9.7
26 - 35	21	11.4
36 - 45	42	22.8
46 - 55	88	47.8
56 +	16	8.6
Gender		
Male	108	58.4
Female	76	41.1
Marital Status		
Single	27	14.6
Married	154	83.2
Widowed	1	.5
Living with Immediate Family		
Yes	166	89.7
No	18	9.6
Living with Other Relatives		
Yes	30	16.2
No	151	81.6
Yearly Family Income		
<\$10,000	12	6.5
\$10,0001-\$15,000	2	1.1
\$15,001-\$20,000	4	2.2
\$20,001-\$35,000	9	4.9
\$35,001-\$50,000	12	6.5
\$50,001-\$70,000	10	5.4
\$70,001-\$99,000	14	7.6
>\$100,000	121	65.4

Table 1 (Continued)

Number in Household		
1	9	4.9
2	24	13.0
3	30	16.2
4	82	44.3
5	27	14.6
6	7	3.8
7	5	2.7
Educational Level		
College Degree	18	9.7
Professional Degree	166	89.7
Amount of Education in U.S.		
None	48	25.9
Some	94	50.8
Most	21	11.4
All	15	8.2
Currently Employed		
Yes	169	91.4
No	12	6.5
Occupation		
Medical	136	73.5
Computer	15	8.1
Engineering	27	14.6
Law	3	1.6
Other	4	2.2
Place of Birth		
US	7	3.8
India	151	81.6
Other	26	14.1
Years In US		
1 - 10	24	13.0
11 - 20	84	45.6
21 - 30	72	39.1
Generational Status		
First	171	92.4
Second	10	5.4
Third	4	2.2

Table 1 (Continued)

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Native Language		
English	19	10.3
Gujurati	51	27.6
Malayalam	18	9.7
Punjabi	12	6.5
Kannada	6	3.2
Hindi	39	21.1
Tamil	6	3.2
Telugu	21	11.4
Marati	1	.5
Experience with Mental Health System		
Yes	15	8.1
No	169	91.4
Type of Service Used		
Inpatient	4	2.2
Outpatient	18	9.7
None	162	87.6
Service Rendered By:		
Psychologist	18	9.7
Psychiatrist	4	2.2
None	162	87.6



remain anonymous and confidential. Participant selection was made by a random choice of names from the compiled subject pool. A self-addressed postage paid envelope was also included in the packet to assist in the return of materials. A postcard was provided, to be mailed back separately from research materials, for those subjects interested in obtaining feedback about the study's results. A description of the questionnaires used in the study are described below.

### Measures

#### American-International Relations Scale (AIRS)

The American-International Relations Scale (AIRS; Sodowsky & Plake, 1991) is a 34-item scale that is intended to assess international people's perceptions of their social psychological adjustment in values, behaviors, cultural practices, and language usage and proficiency in a Caucasian-dominant society. Item content was designed to cover three of Berry's (1980) four options of acculturation: assimilation, integration, and rejection. A few items were adapted from the Acculturation Rating Scale for Mexican Americans (Cuellar et al., 1980) to assess the content areas of values, cultural customs, ethnic pride, and interethnic distance, as suggested by Padilla (1980). For scoring purposes, a Likert scale was employed with values of 1 through 5 for item numbers 1 to 8 and with values 1 through 6 for item numbers 9 to 34. Item numbers 19, 22, 27, and 28 are to be reversed. For the Likert

scales, 5 or 6 indicates strong agreement and 1 indicates strong disagreement. For both multiple choice and Likert items, 1 indicates strong affiliation with Americans, suggesting assimilation. For the Likert items, 6 indicates strong affiliation with one's nationality group, and for the multiple choice, 5 indicates the same, suggesting rejection of American culture or observance of traditionality. The middle score indicated an ability to assume both worlds, with denial of neither, suggesting integration or biculturalism (Sodowsky & Plake, 1991). Scores derived from the items are grouped together and averaged to calculate a Full Scale score and the following factor scores: Perceived Prejudice, Acculturation, and Language Usage. The aforementioned scales are reported to possess coefficient alphas of .88, .79, .82, and .89 respectively. The measure takes approximately 10 minutes to complete. A copy of the AIRS is presented in Appendix B.

#### The Expectations About Counseling Questionnaire (EAC)

The Expectations About Counseling Questionnaire (EAC;Tinsley & Harris, 1976) is a 66-item scale that is intended to assess all of the theoretically important expectancies a prospective client holds about counseling. The scale has been tested on subjects with no prior counseling experience. The EAC examines expectations regarding counselor attitudes and behaviors, characteristics, characteristics of the counseling process, and the quality of the counseling

outcome. The internal consistency of the EAC's 20 scales range from .77 to .89, with a median reliability of .82. Scale scores on the EAC are calculated by summing the responses to the items assigned to each scale and dividing by the number of items. The scale score categories are Responsibility, Openness, Motivation, Attractiveness, Immediacy, Concreteness, Outcome, Acceptance, Confrontation, Genuineness, Trustworthiness, Tolerance, Directiveness, Empathy, Expertise, Self-disclosure, and Nurturance. Scale scores above 6 are considered high and scores below 4 are considered low in their respective qualities. Once scale scores are calculated, factor scores for Personal Commitment, Facilitative Conditions, Counselor Expertise, and Nurturance can be obtained by averaging the appropriate scale scores for each factor. The measure takes approximately 15 minutes to complete. Items of the EAC are rated on a 7-point Likert-type scale with a score of 1 indicating strong disagreement and a score of 7 indicating strong agreement. Each factor score is a composite of 17 different scale scores. A copy of the EAC is presented in Appendix C.

#### The Profile of Mood States (POMS)

The Profile of Mood States (POMS; McNair, 1971) is a 65-item, five point adjective rating scale commonly used to identify affective mood states and mood changes. The measure takes five minutes to complete and delivers scores that can be

interpreted statistically and clinically. The POMS provides six mood factor scores in the following domains: Tension-Anxiety, Depression-Dejection, Anger-Hostility, Vigor-Activity, Fatigue-Inertia, and Confusion-Bewilderment. Individuals completing the POMS are asked to determine how much of a particular mood state has been experienced during the past week, including the day the scale is completed. Reliability for the POMS was determined by calculating coefficient alpha by means of the Kuder-Richardson-20 formula. The standardized item alpha for the POMS for the most recent standardization group ( $N = 1000$ ) was .86. The specific standardized item alpha values for the six scales of the POMS varied from .84 to .95. Test/retest reliability for the measure was established at .66 with the retest four weeks later. A copy of the POMS is presented in Appendix D.

#### Demographic Questionnaire (DQ)

A demographic questionnaire was designed specifically for this study to obtain information concerning the age, gender, education level, occupation, and marital status of the participants. The DQ also includes questions concerning family structure, language use, and ethnic background. Participants were also asked to rank order their preferences regarding counselor characteristics from a roster of personality traits and counseling qualities. A copy of the DQ is presented in Appendix E.

## CHAPTER IV

### RESULTS

Hypothesis I stated that as the measured level of Western acculturation increases, Western acculturated Asian Indian professionals would hold more positive attitudes toward seeking help from mental health professionals than their peers who were less Western acculturated. To analyze this hypothesis a Oneway Analysis of Variance (ANOVA) was conducted. The grouping variable, level of acculturation (Low or High), was determined by the scores received from the acculturation scale of the AIRS. The groups were created by median splits. The dependent variable, mental health help seeking attitude, was determined by scores derived from the Personal Commitment and Facilitative Conditions Scales of the EAC.

The ANOVA indicated significant differences between respondents who were high vs. low in Western acculturation ( $F(1,159) = 3.42, p < .05$ ). Post Hoc analyses revealed that individuals who were more Western acculturated ( $M = 4.99$   $SD = .88$ ) held a greater personal commitment toward seeking mental health services than their peers who were less acculturated ( $M = 4.81$   $SD = .99$ ). Significant group differences were also found with regard to the expectations the respondent held toward counseling ( $F(1,156) = 4.06, p < .05$ ). Post Hoc analyses disclosed that individuals who are more highly Western acculturated ( $M = 5.25$   $SD = .82$ ) held more positive

towards seeking help from mental health professionals than Asian Indian professionals who have not had previous experience/contact with the Western mental health care system. A Oneway ANOVA was conducted to analyze this hypothesis. The grouping variable, previous experience with the mental health care system (i.e. Experience vs. No experience), was determined by the responses received from the DQ and the dependent variable, attitude toward help seeking, was derived by scores received from the Personal Commitment Scale of the EAC.

The ANOVA indicated significant differences between respondents who had experience vs. no experience with the Western mental health care system ( $F(1,179)=4.86, p<.05$ ). Post Hoc analyses revealed that Asian Indian professionals who had previous contact/experience with the Western mental health service system ( $M = 5.23$   $SD = .71$ ) possessed a more positive attitude toward Western mental health services than their peers with no previous contact with the Western mental health service system ( $M = 4.89$   $SD = .95$ ).

Hypothesis V stated that Asian Indian professionals who were more Western acculturated would be less likely to prefer mental health care providers who were of the same race than Asian Indian professionals who were less Western acculturated. In order to analyze this hypothesis, Chi-Square analyses were computed on a 2 X 2 matrix. The independent variable, level of acculturation (High vs Low), was determined by the AIRS. The

dependent variable, counselor race preference (Same vs Different), was derived from the DQ. This analysis yielded no significant effects, ( $\chi^2(1)=3.59, p=.16$ ). However, two Chi-square analyses assessing the relationship between gender and counselor age preference ( $\chi^2(1)=9.61, p<.05$ ) and gender and counselor race preference ( $\chi^2(1)=6.78, p<.05$ ) were statistically significant. A substantial proportion of the female respondents (52.7%) indicated a preference for a counselor who was older than themselves and 48.7% of the female participants indicated a preference for a counselor of similar race. In contrast, the majority of male respondents (66.7%) indicated a preference for counselors of the same age as themselves and 61.1% of the male participants indicated a preference for a counselor of a different race.

#### Additional Analyses

To further determine the relationship of acculturation and the attitudes and use of mental health care among Asian Indians, several Pearson Product-Moment correlations were computed. The results of these analyses revealed that as the level of acculturation increases, the likelihood of using mental health services increases ( $r=.18, p<.05$ ). Asian Indian females tend to indicate greater personal commitment toward ( $r=.20, p<.01$ ) and positive expectations about ( $r=.17, p<.05$ ) the counseling experience.

Results also revealed that as the generational status of

the respondents increases they were more likely to experience mood disturbance ( $r = .20$ ,  $p < .01$ ). Conversely, the results also indicated that as the age of participants increased, their level of mood disturbance decreased ( $r = -.34$ ,  $p < .01$ ).

In order to further explicate the aforementioned findings, two Stepwise Regression Analyses were conducted. The variables of gender, level of acculturation, and previous experience with the mental health service system were analyzed to assess the degree to which they are predictive of attitudes toward mental health services in this population. Results of this analysis revealed that gender accounted for 5.1% of the variance which is significant beyond the .01 level. Previous experience with the mental health care system and level of acculturation were not statistically significant. The results of this regression analysis are presented in Table 2.

In the second Stepwise Regression analysis, the variables of gender, age, and generational status were analyzed to assess the degree to which they are predictive of the level of mood disturbance in this sample. Results of this analysis revealed that age and generational status accounted for 10.9% and 12.9% of the variance respectively ( $p < .05$ ). Gender was not statistically significant. The results of this regression analysis are presented in Table 3.



Table 2

Step-wise Regression Analysis of Attitudes Toward Mental  
Health Services

Step	Variable	Beta	DF	r <sup>2</sup>	F	p
1	Gender	.2436	1,158	.051	9.56	.002
2	Level of Acculturation	-.0809	2,157	.053	5.46	.005
3	Previous Experience	-.0658	3,156	.051	3.87	.010

Table 3  
Step-wise Regression Analysis of Mood Disturbance

Step	Variable	Beta	DF	$r^2$	F	p
1	Age	-.3388	1,158	.109	23.21	.000
2	Generational Status	.1468	2,157	.129	4.98	.027
3	Gender	-.0897	3,156	.132	1.59	.209

## CHAPTER V

### DISCUSSION

The intent of this study was to assess the relationship between acculturation and the attitudes toward utilization of mental health services among Asian Indian professionals. There were five hypotheses advanced, two of which were supported by the data collected.

As hypothesized, the results of this study indicate that Asian Indian professionals who are highly Western acculturated tend to have more positive attitudes toward mental health services than their peers who are less acculturated. This finding was consistent with the results reported by Sue and Sue (1990), and supports the view that individuals with a greater level of Asian ethnic identification may be less likely to utilize mainstream psychological services in the U.S. It also suggests, in support of Cheung and Snowden (1990), that a different system or marketing of mental health care delivery may be necessary to effectively serve the needs of Asian Indian individuals who possess a more traditional value system. It must be noted that 10% of the sample indicated that English was their primary language. This data may suggest a minor confound with acculturation in this study.

The findings of this study do seem to suggest that greater levels of acculturation and formal education are significantly associated with less pejorative attitudes toward

mental illness and mental health care. It appears that this sample of Asian Indians have been able to incorporate contrasting perspectives about mental health into their traditional value systems; consequently, they are more likely to perceive mental health services more positively and utilize them if the need arises. However, this research clearly indicates that not all Asian Indians hold this perspective.

Results of the study revealed that Asian Indian professionals who had previous encounters with the American mental health system held more positive attitudes toward seeking assistance from it. In addition, participants' level of acculturation also seemed to play a key role in their attitudes toward mental health services. Asian Indian professionals who are more Western acculturated and had previous counseling experience indicated a stronger personal commitment to using mental health services than their peers who were less acculturated and had no previous experience. It is evident that having a positive experience or exposure to mental health care plays a vital role in shaping positive attitudes toward mental health services.

If the goal of the administrators of the mental health care delivery system in the U.S. is to develop a system that is accessible by all members of society, then it is important to consider the different requirements voiced within the target population. This goal can be better achieved if the components of the system are isolated (e.g., conceptualization

of mental illness, availability of services, accessibility, attitudes toward illness, service, and mental health care providers) and prevalent attitudes toward each component are thoroughly assessed.

It was also hypothesized that the level of Western acculturation of the subjects would vary with the age of the subject. The findings of this study, limited by a disproportionate distribution of ages (21.1% below age 35 and 79.2% greater than age 35), did not support this assertion. It must be noted that age and generational status are not interchangeable terms and that the sample size of the present study limits the interpretation of results obtained for these variables. It may be that Asian Indians form an ethnic identity by the time they attain professional status in the U.S. and that it is unlikely to significantly change. For example, Sodowsky and Carey (1988) found that older Asian Indians may adhere to their ethnic heritage more firmly, particularly if they live in a potentially isolative environment, the likes of which immigration to the U.S. may produce. Changes in ethnic identification should be studied on a developmental continuum, utilizing a broader range of ages, levels of education, and socio-economic status in order to clarify this issue.

It was hypothesized that as generational status since immigration increases among Asian Indian professionals, their level of Western acculturation would also increase. There were

insufficient numbers of second and third generation Asian Indians to test this hypothesis as originally intended. This is a relatively young immigrant group, as evidenced by the 92.4% of respondents who indicated that they were first generation immigrants. It will be important to follow this immigrant group and compare their collective ethnic transformation to other minority groups. As the socio-political environment changes, each generation will face different challenges of acculturation and consequently have different requirements of the mental health care system. An important task of future researchers would be to explore the nature of the relationship between generational status/differences, ethnic identity development, and subsequent impact on attitudes toward seeking help from mental health professionals by Asian Indians.

Gender differences regarding attitudes toward mental health service utilization were identified by the present study. It was determined that Asian Indian females demonstrated more positive attitudes toward a counseling experience than Asian Indian males. Gender was more predictive of a positive attitude toward mental health service than previous experience or acculturation level. This finding follows previous research that indicates there are gender based differences in communication styles and expectation about counseling. Asian Indian males indicated a preference for counselors of a different race. Interestingly, for Asian

Indian females, preference for counselor race and age were found to be statistically significant. As discussed with regard to the previous hypotheses, these findings may suggest the influences of differences in gender socialization with respect to the types of mental health care providers that Asian Indian women prefer.

One interpretation of this finding may be that the process of Western style counseling is found to be similar to the socialization process in traditional Asian Indian society, in which women are encouraged to share their problems with other women without this being an indication of emotional weakness. Males in traditional Asian Indian society are often likely to be socialized to cope with their problems in a more isolative manner. This difference may suggest that Asian Indian females would be better prepared by their socialization process to utilize counseling services regardless of their acculturation level. In addition, Asian Indian males' preference for counselors of a different race may be attributed to pressures of social and cultural expectation for gender role. The mental health profession can address these gender specific issues by advocating an awareness and sensitivity of gender differences, educating the Asian Indian population about available options, providing accessible and appropriate resources to those in need.

Results from this study revealed that the relationship between acculturation level and preference for counselor race

was not statistically significant. Similar to Jones' (1982) research that did not support the belief that psychotherapy outcome varied as a function of client and therapist race, the findings of this study are contrary to popular expectation. One interpretation of this finding can be understood in the context of the Minority Identity Development model developed by Morten and Atkinson (1983). Individuals in Stage III of this model (Synergetic Articulation and Awareness) are identified by the ability to selectively incorporate values and behaviors from both the minority and dominant cultures. The Asian Indian professionals in this study may be in Stage III and demonstrate indifference with regard to the race of the counselor, as confirmed by Morten and Atkinson's (1988) findings. Another possible explanation for these results may be that social desirability may have influenced the responses of the participants to the questionnaire packet used in the research. This influence may have confounded the results of this study.

Results regarding counselor age preferences are in keeping with the traditional attitudes of the population. Within the Asian Indian community, considerable respect is conferred on elders. Older individuals are revered for their experience and relied upon for guidance. Asian Indians also tend to keep problems and concerns within a limited circle of peers. The Asian Indian communities in the U.S. serve as substitutes for the extended family structures common in



India; therefore, by preferring to see counselors of a similar race, there remains the inclination to share problems with only those who are culturally similar. In order for Asian Indian females to utilize the mental health care system, they must perceive that there are counselors available that conform to these preferences. Further research is recommended to identify the aspects of counseling that interact with gender specific preferences so that counseling experiences result in more positive attitudes toward seeking help.

One of the more interesting findings of the study revealed that younger Asian Indians and/or those who were of second and third generational status had greater mood disturbances, as assessed by the POMS. Regression analyses also found that age and generational status were significantly predictive of mood disturbance. The nature of these results seem to support previous literature (Griffith, 1983) that suggests that individuals who are bi-cultural (i.e., Mexican-American) often experience greater levels of social/psychological stress than their peers who are monocultural (i.e., native Mexicans). There may be something inherently different about the Asian Indians who chose to emigrate from India, that protects them from acculturative stress. In that respect, this group of first generation immigrants differ from other minority populations in the U.S. who may have immigrated due to political and economic

pressures. It may be that the first generation Asian Indian professionals may have reached a level of social, professional, or economic security that buffers some of the stressors of biculturality.

As with all social science research, this study possessed several limitations. The study is weakened by the possibility of a self-selection bias and a narrow sample base. Replication with a more diverse and balanced sample is indicated.

### Summary

Results of this study support the findings of Sue and Sue (1990) that indicate that individuals with greater levels of Asian ethnic identification would be less likely to utilize mainstream psychological services. The level of acculturation and previous experience with the health care system appears to be related to less pejorative attitudes toward mental health illness and more positive attitudes toward the use of mental health services. Asian Indian females were found to hold more favorable views toward mental health services than their male counterparts. The age and race of a counselor appear to be of particular concern for Asian Indian females.

APPENDIX A  
COVER LETTER

Dear Sir or Madam,

In an effort to assess the Asian Indian community's attitudes and beliefs about counseling and mental health services, we are asking you to take a few moments to fill out the accompanying questionnaires and return them **at your earliest convenience** in the pre-addressed, business return envelope provided. **Please be sure to fill out all pages. This is a confidential questionnaire, do not put your name on any of the items being returned in the envelope or on the envelope itself.** Packets should be completed by the person to whom it is addressed. You may receive more than one packet per household. If you would like to receive the results of our study, please send your request separately. You will receive the results when the study is completed later this year. Your participation is greatly appreciated, and if you have any questions about the study please contact me at the following address: Vinita Menon

Department of Psychology  
Loyola University Chicago  
6525 N. Sheridan Road  
Chicago, IL 60626  
(708) 508-3002

Sincerely,

Vinita Menon  
Graduate Student  
Loyola University of Chicago

Isiaah Crawford, Ph.D.  
Professor of Psychology  
Loyola University Chicago

APPENDIX B  
AMERICAN-INTERNATIONAL RELATIONS

American-International Relations Survey (AIRS)

This questionnaire attempts to understand some experiences of people from different countries (e.g., international students, non-immigrant professionals, permanent residents, naturalized citizens, second generation immigrants, etc.) living in the U.S. Do not write your name anywhere on this questionnaire.

Directions: Please check the appropriate blank. Check only one blank per question--the one that you think describes you the best.

1. The language(s) I speak well are

- ☐ 1. English only
- ☐ 2. Mostly English, some my first language (mother tongue)
- ☐ 3. English and my first language equally well
- ☐ 4. Mostly my first language, some English
- ☐ 5. My first language only

2. When I am with people from my country I speak

- ☐ 1. English only
- ☐ 2. Mostly English, some my first/national language
- ☐ 3. English and my first/national language equally
- ☐ 4. Mostly my first/national language, some English
- ☐ 5. My first/national language only

3. Friends with whom I am close are

- ☐ 1. Americans only
- ☐ 2. Mostly Americans, some people from my country
- ☐ 3. Americans and people from my country equally
- ☐ 4. Mostly people from my country, some Americans
- ☐ 5. People from my country only

4. When I think, my ideas and images best operate

- ☐ 1. In English only
- ☐ 2. Mostly in English, some in my first language
- ☐ 3. In English and my first language equally
- ☐ 4. Mostly in my first language, some in English
- ☐ 5. In my first language only

5. People I trust and turn to when I need help are

- ☐ 1. Americans only
- ☐ 2. Mostly Americans, some my family
- ☐ 3. Americans and my family equally
- ☐ 4. Mostly my family, some Americans
- ☐ 5. My family only

6. I like to eat

- ☐ 1. Only American food
- ☐ 2. Mostly American food, some my country (or region) food
- ☐ 3. American and my country (or region) food equally
- ☐ 4. Mostly my country (or region) food, some American
- ☐ 5. Only my country (or region) food

7. I believe my group identity to be related
- ☐ 1. Only to American society
  - ☐ 2. Mostly to American society, some to the country/state I come from
  - ☐ 3. To American society and to my country/state equally
  - ☐ 4. Mostly to the country/state I come from, some to American society
  - ☐ 5. Only to the country/state I come from
8. I believe myself to be an individual
- ☐ 1. With many similarities with Americans
  - ☐ 2. With some similarities to Americans
  - ☐ 3. Equally similar to Americans and to people from my country
  - ☐ 4. With some similarities with people from my country
  - ☐ 5. With many similarities with people from my country

Directions: Mark each of the following statements according to how much you agree or disagree with it. There is no right or wrong answer. The best answer is your personal opinion. Please express what you actually believe to be true rather than what you wish were true. If you do not have a definite opinion about a statement, choose a degree of agreement or disagreement that comes closest to what you think. Please respond to every statement. Please use the following rating scale:

1:Disagree Strongly    2:Disagree    3:Tend to disagree    4:Tend to agree    5:Agree    6:Agree Strongly

- ☐ 9. Americans try to fit me into the stereotypes that they have about my nationality group.
- ☐ 10. I find Americans overly concerned about their personal needs.
- ☐ 11. I find that when I am with a group of Americans, the Americans almost always talk to each other and ignore me.
- ☐ 12. If/when I don't dress in American fashions, Americans think I am odd, backward, or not to be taken seriously.
- ☐ 13. American institutions (e.g., professional associations, major universities, or government agencies) are trying to place official or unofficial restrictions on me or people from my country gaining admission into educational, work or professionals areas in which my nationality group has achieved visible numbers and success.



1:Disagree Strongly    2:Disagree    3:Tend to Disagree    4:Tend to Agree    5:Agree    6:Agree Strongly

- \_\_\_\_\_ 14. I resent that I am often overlooked for recognition (e.g., an award for academic achievement), special projects, hiring, or promotion.
- \_\_\_\_\_ 15. No matter how adjusted to American ways I may be, I will be seen as a "foreigner" by Americans.
- \_\_\_\_\_ 16. If I did not have some family members, or relatives, or some friends among people from my country living in the USA, I would feel isolated.
- \_\_\_\_\_ 17. My physical appearance does not match the standards that Americans have about good looks.
- \_\_\_\_\_ 18. I believe Americans are only interested in me on the surface level.
- \_\_\_\_\_ 19. I prefer American music, films, dances, and entertainment to those of my country of origin.
- \_\_\_\_\_ 20. Americans think I come from a country with strange, primitive customs.
- \_\_\_\_\_ 21. Americans don't care to know about my religion, culture, national history, values, or lifestyle.
- \_\_\_\_\_ 22. I have more American friends than friends among people from my country.
- \_\_\_\_\_ 23. I believe I will never fully understand how to function successfully in the American bureaucracy or "system" (educational, governmental, professional, or business operations).
- \_\_\_\_\_ 24. I adhere strictly to my religion and cultural values.
- \_\_\_\_\_ 25. I feel I am not fully accepted in organizations which have a majority of American members.
- \_\_\_\_\_ 26. Americans are too assertive and verbal for my liking.
- \_\_\_\_\_ 27. I celebrate American religious or social festivals more than I celebrate my country's religious or social festivals.
- \_\_\_\_\_ 28. I believe the best way to appear less "different" to Americans is to become like American society and people.

1:Disagree Strongly    2:Disagree    3:Tend to Disagree    4:Tend to Agree    5:Agree    6:Agree Strongly

- \_\_\_ 29. I seek the friendship and support of people from my country in the city/town I am living.
- \_\_\_ 30. The Americans I study or work with feel threatened by my strengths and successes.
- \_\_\_ 31. In my study or work environment I follow American ways and standards, but at home I follow many customs of my country of origin.
- \_\_\_ 32. Americans believe that my foreign accent, or nonfluent English, or lack of knowledge of American expressions is a sign of ignorance.
- \_\_\_ 33. I believe it is more proper to marry someone from one's own nationality group than an American.
- \_\_\_ 34. I am rarely invited to the home or parties of my American classmates, colleagues, or neighbors.

APPENDIX C  
EXPECTATIONS ABOUT COUNSELING

Expectations About Counseling (EAC)

Pretend that you are about to see a counseling psychologist for your first interview. We would like to know just what you think counseling will be like. On the following pages are statements about counseling. In each instance you are to indicate what you expect counseling to be like. The rating scale we would like you to use is printed at the top of each page. Your ratings of the statements are to be recorded at the end of each statement. For each statement, write the number which most accurately reflects your expectations.

Your responses will be kept in strictest confidence. Your answers will be combined with the answers of others like yourself and reported only in the form of group averages.

When you are ready to begin, answer each question as accurately as possible. Finish each page before going to the next.

NOW TURN THE PAGE AND BEGIN

1	2	3	4	5	6	7
Not True	Slightly True	Somewhat True	Fairly True	Quite True	Very True	Definitely True

---

I EXPECT TO...

1. Take psychological tests.\_\_\_\_
2. Like the counselor.\_\_\_\_
3. See a counselor in training.\_\_\_\_
4. Gain some experience in new ways of solving problems within the counseling process.\_\_\_\_
5. Openly express my emotions regarding myself and my problems.\_\_\_\_

I EXPECT TO...

6. Understand the purpose of what happens in the interview.\_\_\_\_
7. Do assignments outside the counseling interview.\_\_\_\_
8. Take responsibility for making my own decisions.\_\_\_\_
9. Talk about my present concerns.\_\_\_\_
10. Get practice in relating openly and honestly to another person within the counseling relationship.\_\_\_\_

I EXPECT TO...

11. Enjoy my interviews with the counselor.\_\_\_\_
12. Practice some of the things I need to learn in the counseling relationship.\_\_\_\_
13. Get a better understanding of myself and others.\_\_\_\_
14. Stay in counseling for at least a few weeks, even if at first I am not sure it will help.\_\_\_\_
15. See the counselor for more than three interviews.\_\_\_\_

I EXPECT TO...

16. Never need counseling again.\_\_\_\_
17. Enjoy being with the counselor.\_\_\_\_
18. Stay in counseling even though it may be painful or unpleasant at times.\_\_\_\_
19. Contribute as much as I can in terms of expressing my feelings and discussing them.\_\_\_\_
20. See the counselor for only one interview.\_\_\_\_

1	2	3	4	5	6	7
Not True	Slightly True	Somewhat True	Fairly True	Quite True	Very True	Definitely True

---

I EXPECT TO...

- 21. Go to counseling only if I have a very serious problem. \_\_\_\_
- 22. Find that the counseling relationship will help the counselor and me identify problems on which I need to work. \_\_\_\_
- 23. Become better able to help myself in the future. \_\_\_\_
- 24. Find that my problem will be solved once and for all in counseling. \_\_\_\_
- 25. Feel safe enough with the counselor to really say how I feel. \_\_\_\_

I EXPECT TO:

- 26. See an experienced counselor. \_\_\_\_
- 27. Find that all I need to do is to answer the counselor's questions. \_\_\_\_
- 28. Improve my relationships with others. \_\_\_\_
- 29. Ask the counselor to explain what he or she means whenever I do not understand something that is said. \_\_\_\_
- 30. Work on my concerns outside the counseling interviews. \_\_\_\_
- 31. Find that the interview is not the place to bring up personal problems. \_\_\_\_

THE FOLLOWING QUESTIONS CONCERN YOUR EXPECTATIONS ABOUT THE COUNSELOR.

I EXPECT THE COUNSELOR TO...

- 32. Explain what's wrong. \_\_\_\_
- 33. Help me identify and label my feelings so I can better understand them. \_\_\_\_
- 34. Tell me what to do. \_\_\_\_
- 35. Know how I feel even when I cannot say quite what I mean. \_\_\_\_

I EXPECT THE COUNSELOR TO...

- 36. Know how to help me. \_\_\_\_
- 37. Help me identify particular situations where I have problems. \_\_\_\_
- 38. Give encouragement and reassurance. \_\_\_\_
- 39. Help me to know how I am feeling by putting my feelings into words for me. \_\_\_\_
- 40. Be a "real" person not just a person doing a job. \_\_\_\_

1	2	3	4	5	6	7
Not True	Slightly True	Somewhat True	Fairly True	Quite True	Very True	Definitely True

---

I EXPECT THE COUNSELOR TO...

- 41. Help me discover what particular aspects of my behavior are relevant to my problems.\_\_\_\_
- 42. Inspire confidence and trust.\_\_\_\_
- 43. Frequently offer me advice.\_\_\_\_
- 44. Be honest with me.\_\_\_\_
- 45. Be someone who can be counted on.\_\_\_\_

I EXPECT THE COUNSELOR TO...

- 46. Be friendly and warm towards me.\_\_\_\_
- 47. Help me solve my problems.\_\_\_\_
- 48. Discuss his or her own attitudes and relate them to my problem.\_\_\_\_
- 49. Give me support.\_\_\_\_
- 50. Decide what treatment plan is best.\_\_\_\_

I EXPECT THE COUNSELOR TO...

- 51. Know how I feel at times, without my having to speak.\_\_\_\_
- 52. Do most of the talking.\_\_\_\_
- 53. Respect me as a person.\_\_\_\_
- 54. Discuss his or her own experiences and relate them to my problems.\_\_\_\_
- 55. Praise me when I show improvement.\_\_\_\_

I EXPECT THE COUNSELOR TO...

- 56. Make me face up to the differences between what I say and how I behave.\_\_\_\_
- 57. Talk freely about himself or herself.\_\_\_\_
- 58. Have no trouble getting along with people.\_\_\_\_
- 59. Like me.\_\_\_\_
- 60. Be someone I can really trust.\_\_\_\_

I EXPECT THE COUNSELOR TO...

- 61. Like me in spite of the bad things he or she knows about me.\_\_\_\_
- 62. Make me face up to the differences between how I see myself and how I am seen by others.\_\_\_\_
- 63. Be someone who is calm and easygoing.\_\_\_\_
- 64. Point out to me the differences between what I am and what I want to be.\_\_\_\_
- 65. Just give me information.\_\_\_\_

1	2	3	4	5	6	7
Not True	Slightly True	Somewhat True	Fairly True	Quite True	Very True	Definitely True

---

I EXPECT THE COUNSELOR TO...

66. Get along well in the world.\_\_\_\_

STOP

Check to see that you have answered all the questions.



APPENDIX D  
PROFILE OF MOOD STATES

# PROFILE OF MOOD STATES

Below is a list of words that describe feelings people have. Please read each one carefully. Then circle ONE response which best describes HOW YOU HAVE BEEN FEELING DURING THE PAST WEEK INCLUDING TODAY.

0=Not at all 1=A little 2=Moderately 3=Quite a bit 4=Extremely

- |                 |           |                 |           |
|-----------------|-----------|-----------------|-----------|
| 1. FRIENDLY     | 0 1 2 3 4 | 35. LONELY      | 0 1 2 3 4 |
| 2. TENSE        | 0 1 2 3 4 | 36. MISERABLE   | 0 1 2 3 4 |
| 3. ANGRY        | 0 1 2 3 4 | 37. MUDDLED     | 0 1 2 3 4 |
| 4. WORN OUT     | 0 1 2 3 4 | 38. CHEERFUL    | 0 1 2 3 4 |
| 5. UNHAPPY      | 0 1 2 3 4 | 39. BITTER      | 0 1 2 3 4 |
| 6. CLEARHEADED  | 0 1 2 3 4 | 40. EXHAUSTED   | 0 1 2 3 4 |
| 7. LIVELY       | 0 1 2 3 4 | 41. ANXIOUS     | 0 1 2 3 4 |
| 8. CONFUSED     | 0 1 2 3 4 | 42. READY TO    |           |
| 9. SORRY FOR    |           | FIGHT           | 0 1 2 3 4 |
| THINGS DONE     | 0 1 2 3 4 | 43. GOODNATURED | 0 1 2 3 4 |
| 10. SHAKY       | 0 1 2 3 4 | 44. GLOOMY      | 0 1 2 3 4 |
| 11. LISTLESS    | 0 1 2 3 4 | 45. DESPERATE   | 0 1 2 3 4 |
| 12. PEEVED      | 0 1 2 3 4 | 46. SLUGGISH    | 0 1 2 3 4 |
| 13. CONSIDERATE | 0 1 2 3 4 | 47. REBELLIOUS  | 0 1 2 3 4 |
| 14. SAD         | 0 1 2 3 4 | 48. HELPLESS    | 0 1 2 3 4 |
| 15. ACTIVE      | 0 1 2 3 4 | 49. WEARY       | 0 1 2 3 4 |
| 16. ON EDGE     | 0 1 2 3 4 | 50. BEWILDERED  | 0 1 2 3 4 |
| 17. GROUCHY     | 0 1 2 3 4 | 51. ALERT       | 0 1 2 3 4 |
| 18. BLUE        | 0 1 2 3 4 | 52. DECEIVED    | 0 1 2 3 4 |
| 19. ENERGETIC   | 0 1 2 3 4 | 53. FURIOUS     | 0 1 2 3 4 |
| 20. PANICKY     | 0 1 2 3 4 | 54. EFFICIENT   | 0 1 2 3 4 |
| 21. HOPELESS    | 0 1 2 3 4 | 55. TRUSTING    | 0 1 2 3 4 |
| 22. RELAXED     | 0 1 2 3 4 | 56. FULL OF PEP | 0 1 2 3 4 |
| 23. UNWORTHY    | 0 1 2 3 4 | 57. BADTEMPERED | 0 1 2 3 4 |
| 24. SPITEFUL    | 0 1 2 3 4 | 58. WORTHLESS   | 0 1 2 3 4 |
| 25. SYMPATHETIC | 0 1 2 3 4 | 59. FORGETFUL   | 0 1 2 3 4 |
| 26. UNEASY      | 0 1 2 3 4 | 60. CAREFREE    | 0 1 2 3 4 |
| 27. RESTLESS    | 0 1 2 3 4 | 61. TERRIFIED   | 0 1 2 3 4 |
| 28. UNABLE TO   | 0 1 2 3 4 | 62. GUILTY      | 0 1 2 3 4 |
| CONCENTRATE     |           | 63. VIGOROUS    | 0 1 2 3 4 |
| 29. FATIGUED    | 0 1 2 3 4 | 64. UNCERTAIN   | 0 1 2 3 4 |
| 30. HELPFUL     | 0 1 2 3 4 | ABOUT THINGS    |           |
| 31. ANNOYED     | 0 1 2 3 4 | 65. BUSHED      | 0 1 2 3 4 |
| 32. DISCOURAGED | 0 1 2 3 4 |                 |           |
| 33. RESENTFUL   | 0 1 2 3 4 |                 |           |
| 34. NERVOUS     | 0 1 2 3 4 |                 |           |

**APPENDIX E**  
**DEMOGRAPHIC QUESTIONNAIRE**

Demographic Questionnaire (DQ)

Today's date: \_\_\_\_\_ Age: \_\_\_\_\_ years  
(Month) (Day) (Year)

Sex (M or F): \_\_\_\_\_ Birth Date: \_\_\_\_\_  
(Month) (Day) (Year)

Marital Status: \_\_\_\_\_ Married \_\_\_\_\_ Single  
\_\_\_\_\_ Widowed \_\_\_\_\_ Divorced

Do you live with your immediate family? (Y or N) \_\_\_\_\_

Do you live with relatives other than your immediate family  
(mother, father, & siblings)? (Y or N) \_\_\_\_\_

What would you estimate your household income to be? (Please  
check one):

\_\_\_\_\_ \$10,000 or less  
\_\_\_\_\_ 10,001 - 15,000  
\_\_\_\_\_ 15,001 - 20,000  
\_\_\_\_\_ 20,001 - 35,000  
\_\_\_\_\_ 35,001 - 50,000  
\_\_\_\_\_ 50,001 - 70,000  
\_\_\_\_\_ 70,001 - 99,999  
\_\_\_\_\_ 100,000 or more

Number of people (including yourself) in your household: \_\_\_\_\_



Have you ever used mental health services in the U.S.?

☐ YES ☐ NO

If yes, please indicate the type of mental health service, duration of treatment, and year(s) you received it:

☐ Inpatient hospitalization      Duration of Treatment:   
Year: 19

☐ Outpatient Counseling      Duration of Treatment:   
Year: 19

Please indicate the type of mental health professional who provided your primary care (choose one):

☐ Psychologist      ☐ Psychiatrist  
☐ Social worker      ☐ Alcohol/Drug counselor

Please indicate your preference as to the following counselor characteristics.

I would like a counselor who is:

☐ Younger than me      ☐ Older than me      ☐ Same age

☐ The same sex as me      ☐ The opposite sex as me

☐ The same race as me      ☐ A different race than me

Please rank order the following counselor characteristics.

Place a "1" next to the characteristic that is most important to you.

Place a "2" next to the characteristic that is second most important to you.

Place a "3" next to the characteristic that is third most important to you.

AGE       SEX       RACE

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## VITA

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The final copies have been examined by the director of the thesis committee and the signature which appears below verifies the fact that any necessary changes have been incorporated and that the thesis is now given final approval by the committee with reference to content and form.

The thesis is therefore accepted in partial fulfillment of the requirements for the degree of master of arts.

Isiaah Crawford Ph.D.

Director's Signature

4/11/94

Date